Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Refer to: IIO3

May 30, 2003

Melanie Bella, Assistant Secretary
Office of Medicaid Policy and Planning
Indiana Family & Social Services Administration
402 W. Washington Street, Room W382
Indianapolis, Indiana 46204-2739

Dear Ms. Bella:

Subject: Request for a Medicaid Waiver Amendment to Provide Home and Community-Based Services as Authorized Under Section 1915(c) of Social Security Act (Control #0387)

This is in response to Indiana's request to amend its Medicaid home and community-based services (HCBS) waiver for individuals with mental retardation and developmental disabilities as authorized under section 1915(c) of the Social Security Act. The waiver amendment proposes to prioritize 1,800 of the approved unduplicated individuals out of 4,591 for waiver year two for persons identified as waiver eligible who are currently receiving services for the developmentally disabled through Title XX.

This waiver amendment does not propose any change in the approved package of waiver services. The existing waiver provides Respite Care, Adult Day Services, Community Habilitation, Day Habilitation, Prevocational Services, Supported Employment Services, Transportation, Specialized Medical Equipment and Supplies, Personal Emergency Response Systems, Family Training and Skilled Services. It also waives Section 1902(a)(10)(B), which addresses the comparability of services. This waiver amendment has been assigned control number 0387.03.

Centers for Medicare & Medicaid Services' (CMS) staff members have thoroughly reviewed your amendment request and have determined that the current waiver may not fully conform to the statutory and regulatory requirements for approval.

Before we can effectively act on your waiver request, additional information is needed. Since approval of your initial waiver, we have received a legal opinion from our Office of General Counsel rendering the use of caps as targeting criteria for home and community-based waiver programs impermissible. Based on the current waiver application and recent discussions with the State, we understand that you intend the $13,500 cost cap to be waiver targeting criterion; this decision is relevant to two essential aspects of your waiver request. A cost cap of this nature is problematic and inappropriate for several reasons, which are delineated below.

Describing the Target Group

Each HCBS waiver must "describe the group or groups of individuals to whom the services will be offered" (42 CFR 441.301(b)(3)). Eligibility criteria in item 4d on page 2 of the waiver request should be based on *descriptive* criteria of the individual target population rather than the cost of their services.

Descriptive criteria must include a level of care equal to that of equivalent institutional care, and may include a great variety of other attributes of the group in question, such as age, diagnoses, health status, required assistance in activities of daily living, etc.

The cost of an individual's service plan is not a description of the group, but a description of the State's service response to that group. If the State wishes to limit the amount of funding that is provided to the group, then the law permits the imposition of a cost threshold, as described below:

Limiting the Funding for an Individual's Service Plan

States have the option to "refuse to offer home and community-based services to any recipient if the agency can reasonably expect that the cost of the services would exceed the cost of an equivalent level of care provided in (i) A hospital...(ii) A NF...or (iii) An ICF-MR..." (42 CFR 441.301 (a)(3)).

Once a person is determined to meet targeting criteria, a state that has elected the above option may then do a cost comparison of HCBS waiver costs versus institutional costs for an equivalent level of care. Such a cost comparison may then be used to determine whether the person will be served under the waiver (item 8 on page 3 of the waiver request). There are two ways the State can perform the cost comparison.

1. *Person-Specific:* The Medicaid cost of the individual's HCBS waiver service plan may be compared to the cost of serving *this particular individual* in the institutional setting; or

2. *Average Per Capita:* The Medicaid cost of the individual's HCBS waiver service plan may be compared to the State's average per capita cost for the equivalent level of care in the applicable institutional category. These costs must then be reflected in the cost neutrality formula for the waiver.

If the State performs the cost comparison referenced in item 8 on page 3, please indicate whether person-specific institutional costs or average per capita costs will be used. If average per capita institutional costs are used, please also indicate whether the comparison will be to:

(a) *All Levels of Institutional Care:* 100% (or higher percentage) of the average per capita institutional costs for a weighted average of all levels of care in the applicable institutional category (such as the average ICF-MR cost), or

(b) *Same Levels of Care:* 100% (or higher percentage) of a specific level of equivalent care within the applicable institutional category. For example, the ICF-MR rate structure may identify three levels of care. If an HCBS waiver served only persons at the highest level of care, the state may use that highest level of institutional costs in its cost-neutrality formula for the waiver. Similarly, if you expect to impose a $13,500 threshold for people in the HCBS waiver, we presume that individuals in the waiver would, on average, require a lower level of care than those in the ICF-MR. Such differences in the case mix must be reconciled in the cost-neutrality formula. In this case, the State would use a lower cost of institutional care than the total weighted average for all ICFs-MR residents. We appreciate that the rate-setting or reimbursement structure for ICFs-MR in some states does not include case mix adjusters. If this is the case, please consult with us and we will work with you on options for an acceptable methodology.

Again, we emphasize that the cost comparison in item 8 on page 3 is a threshold for determining whether an individual will be served on the waiver (thus ensuring the cost-neutrality of the waiver) rather than a cap on the cost of services provided once the individual is placed on the waiver. The State should consider if there is an alternative approach, in lieu of establishing a per recipient cost cap, that will allow it to achieve the same end. For instance, the State may chose to incorporate expenditure limitations in the service definitions. If the State were to choose this approach, however, CMS would expect that the limitations be reasonable and that the State demonstrate how the limitation is established. Furthermore, the State would also be expected to provide its process/methodology regarding how it will protect health and welfare when recipients meet service limitations. The State's process/methodology may include a prior authorization process, development of crisis intervention/crisis support services, and transition to another waiver or State-funded services/supports. Thus, since an expenditure limit is being proposed for Respite Care, please indicate how the limit was established and describe what will happen when a participant reaches the maximum expenditure limit and meeting his/her needs would necessitate exceeding the limit.

Please forward your response to this request for information to the Regional Office along with a copy to:

Mary Jean Duckett, Director
Division of Benefits, Coverage, and Payment
Centers for Medicare & Medicaid Services
Mail Stop S2-14-26
7500 Security Boulevard
Baltimore, Maryland 21244

Under Section 1915(f)(2) of the Social Security Act, an HCBS waiver request must be approved, denied or have additional information requested within 90 days of receipt by CMS or the request will be deemed approved. The 90th day on this waiver request is June 9, 2003. Please consider this letter a formal request for additional information that stops the 90-day clock. Once the additional information is received by CMS, the 90-day review clock will start at day one.

Please contact LaVern Ware in our Baltimore, Maryland office at (410) 786-5480 or contact Bertha Ortiz of my staff at 312-353-9860 if you need additional information.

Sincerely,

/s/
Cheryl A. Harris
Associate Regional Administrator
Division of Medicaid and Children's Health

cc: Mary Jean Duckett, CMSO
Korryn Fairman, OMPP
Evelyn Murphy, LTC/IFSSA